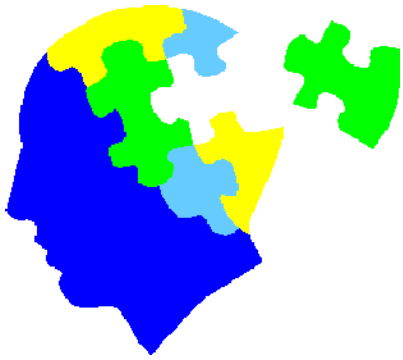
Social Problem Solving Therapy

For Depression and Executive Dysfunction



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CHAPTER 1: DEPRESSION & EXECUTIVE DYSFUNCTION

Introduction

Depression is a frequently occurring and disabling disease. Rates of depression in older adult populations are predicted at an estimated 5-10% (Koenig & Blazer, 1992). Though many treatments for depression are effective, treating depression in elderly populations is complicated by several factors that are not common in other populations. 75% of individuals over 60 years of age have a medical illness (Klerman, 1983). In addition, mild levels of cognitive impairment may occur as a result of healthy aging processes or even pre-clinical phases of dementing conditions such as Alzheimer's disease and Ischemic Vascular disease. The comorbidity of a medical illness or mild cognitive impairment, can complicate the singular treatment of depression. Financial resources, as well as other accessibility resources, also limit many older persons in attaining the mental health care they need. For these reasons, treatment for elderly with depression is best received as a treatment that is effective, brief, and has flexible delivery options (e.g. primary care or other facility). This manual describes one such treatment that not only addresses the needs of older persons for short-term treatment delivered in a variety of settings, but also a treatment that attends to the potential mild cognitive impairment that is common among the elderly.

Diagnosis of Depression

Diagnosis of depression in the elderly requires presentation of symptoms described below. For a diagnosis of a Major Depressive Episode, individuals must present with five or more of the following symptoms for a 2-week period:

1. depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g. , appears tearful)

2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

3. significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.

4. insomnia or hypersomnia nearly every day

5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

6. fatigue or loss of energy nearly every day

7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (DSM IV).

Once diagnosis of depression is made, the patient or his or her caregiver must also care for possible comorbid conditions. As indicated previously, in elderly patients, presence of mild cognitive impairment is quite common and must be included in the diagnosis in order for an appropriate course of treatment to be selected.

Cognitive Model of Depression

Depression, with or without comorbid disorders, is generally conceptualized as multifactorial in etiology. Research has shown depression to be linked to environmental, genetic, and biological factors. Several models incorporate the contributing elements. The Cognitive Behavioral model of depression, for example, hinges on the cognitive triad: the negative view of the self, the negative view of experience, and the negative view of the future (Beck, 1979). Patient's negative conceptions of interpersonal interactions, daily events, and of themselves can precipitate depression. Cognitions that have been learned through experience yield outlooks that may be more negative or unrealistic. The attitudes (schemas) cause the depressed individual to interpret events and problems in a negative light. The emotions and cognitions the individual might then have would be based on these negative perceptions of both external and internal factors, and might lead into a depressive episode. Cognitive therapy targets these negative cognitions and reframes these distorted and negatively biased cognitions with a more

balanced and realistic conceptualization of external and internal events, emotions, and interpersonal relationships. The purpose of a cognitive behavioral therapy for depression is to challenge negative cognitions in hopes of facilitating a balanced and realistic perspective for the patient. In this way the patient is able to attack problems strategically and prevent further depressive cycles. One example of a cognitive behavioral therapy, supported by empirical evidence to be effective in populations of older adults (Areán et al., 1993) is Social Problem Solving Therapy (SPST). SPST offers older adults an empirically supported treatment geared towards treatment of depression by teaching problem solving skills to patients so that they can address their negative perceptions and cognitions while in therapy and upon completion of treatment, be able to continue to do with the skills they have acquired.

Executive Dysfunction

Treatment with SPST as well as other treatments, in older adult populations can be complicated by commonly occurring mild cognitive impairments or pre-clinical neurological degeneration. Executive functioning is a domain of cognitive functioning that when impaired can create significant impairments in an individuals daily functioning. Impairments in this domain of cognitive functioning, commonly referred to as "executive dysfunction", and typically refers to cognitive functions that are governed by the frontal regions of the brain. Changes in executive functioning can be detected through the use of neuropsychological tests, but also through the use of behavioral observations. Executive functioning is a complex cluster of skills and abilities that drive many other cognitive processes. These processes constitute a higher order system of cognition and include

such aspects as behavioral initiation, planning, hypothesis generation, problem solving, cognitive flexibility, decisions making, self-awareness, and judgment (Lezak, 1995). The components of executive functioning allow the individual to engage in a broad spectrum of purposeful, self-motivated plans and behaviors. When these functions are impaired many aspects of behavior may be impacted. Among older adults, many individuals will be likely to have difficulty in initiation and motivation, planning and strategizing a task or activity, apathy, or poor judgment and decision making skills. Mild cognitive impairment, especially in the form of executive dysfunction further complicates the treatment of Depression. Studies (Mayberg, 1997; Pizzagalli et al, 2001) have shown that executive dysfunction is linked to a poor and unstable response to treatment of geriatric depression with antidepressant medication, increased disability, and increased relapse rates. As a result, it will be important to adapt our traditional treatments for use with this commonly occurring problem. Social Problem Solving Therapy does this by means of structurally laying out the steps of problem solving. This is helpful for individuals with executive impairments because the behavioral steps of problem solving and decision-making are structured, concrete and provided in the overall framework. This will reduce the autonomy generally required to manage personal difficulties and provide the patient with a manageable framework to solve problems which otherwise would serve to worsen depressive symptoms.

CHAPTER 2: SPST

Adaptations of SPST for Executive Dysfunction

SPST-ED is an adaptation of SPST specified for individuals with comorbid depression and executive deficits. It has the benefit of contiguous treatment of both depression and executive dysfunction. Though the steps to SPST-ED are similar to that of SPST (described in Chapter 4), the delivery of the treatment differs in that the therapist will take a more active role in the treatment, both during the session as well as outside allotted session time. Additionally, SPST-ED encourages the therapist to increasingly rely on external reminders and mnemonic devices to aid in assisting the patient with initiation, memory, and prompting in independent tasks. The therapist will also progress more slowly through the problem solving components in order to be certain that the patient has adequate comprehension of the concepts prior to moving on to the next step. Therapists and/or caregivers must be cognizant that these patients may take somewhat longer to acquire these skills and include checks of patient comprehension and adherence and possibly repetition to ensure the patient can benefit from treatment.

CHAPTER 3: CASE EXAMPLE

Case Example: Mrs. Q

The following is an illustration of a patient presenting with both depressive complaints and symptoms of executive dysfunction:

Mrs. Q, a 79-year-old woman, developed depression after her daughter, who was her main support, moved to another state. The patient reports that her daughter was her

"touchstone", the person she could count on to help her with day-to-day activities, and could be relied on in a crisis. Since the move, Mrs. Q. reports being unable to begin and complete basic daily activities such as grocery shopping, preparing meals, and keeping track of medicine she must take. Upon further probing, she reports that when faced with having to complete these tasks, she finds them difficult to do – she cannot decide what she needs to buy, what she should eat, or how to develop a plan to remember taking her medicines. The typical day starts with her intention to pay her bills, or to call her landlord about problems in her apartment, but instead she tends to spend all day in her nightgown and accomplishes very little. In addition, she reports feeling tired and unmotivated, neglects her appearance, and has given up cooking or doing work around the house. She complains of depressed mood and indicates that there is little reason for her to go on. Further, she reports that while she was always a bit of a procrastinator, it has only been since her daughter moved away that she began having difficulty with every-day activities. Her medical status is stable but she has a history of hypertension, atrial fibrillation and of a transient ischemic episode, which resulted in reversible aphasia and right-sided hemiparesis 6 months earlier. On examination, she is disheveled; her response to questions is brief, and she is somewhat suspicious when presented with difficult questions. Her Mini Mental Status Examination (MMSE) score is 27. With respect to spontaneous response generation or fluency, she is only able to list 9 items that one can buy in a supermarket in one minute and performs poorly on a measure of response inhibition (Stroop color –word task).

Mrs. Q displays symptoms not only of depression, but also of Executive Dysfunction. Her symptoms constellation offers several challenges for treatment planning. First, Mrs. Q has trouble initiating tasks, including initiating tasks that typically have clear solutions. Second, Mrs. Q struggles with conceptualizing new ways of approaching a problem that she has unsuccessfully tackled repeatedly with a poor strategy. Third, patients in Mrs. Q's position have trouble moving past the first solution they have brainstormed. Their perseveration on the first solution does not provide them the flexibility to discover an appropriate alternative resolution. Fourth, Mrs. Q and patients in her circumstances tend to be highly distractible or tangential. Though they appear to procrastinate and resist treatment, their behavior is neither intentional nor volitional. Rather, their behavior is likely a result of mild levels of neurological impairment. Therapy addressing the needs of patients in Mrs. Q's position must be adapted to work around the challenges faced by the combination of depression and executive dysfunction. Therapists must be aware of the cognitive deficiencies that might complicate treatment and take measures to address these issues.

As stated previously, elderly patients who are depressed but also have Executive Dysfunction appear to not respond well to traditional anti-depressant medication trials. It has been hypothesized (Grigsby et al, 1998; Nadler, 1993) that these changes in cognition create serious behavioral deficits that may be better addressed with psychotherapy targeting important skills to overcome deficits. Social Problem Solving Therapy provides skills that address both depression as well as the skills deficit demonstrated in patients with executive dysfunction. This kind of impairment will likely be best treated by use of

a behavioral intervention in order to overcome the behavioral problems of executive dysfunction.

CHAPTER 4: SPST RATIONALE AND STAGES

Rationale of SPST

Theory behind both PST and SPST is that depression can be dealt with by working on problem solving skills and encouraging patients to address their problems in a systematic fashion so that they will not cycle downwards into a depressive episode. SPST consists of a 12-session schedule, and 5 skills to be learned by the patient so that once the treatment is over, the patient has incorporated the appropriate steps to cope with problems they face (described also in Nezu, Nezu, Perri, 1989). Furthermore, SPST has been shown to be effective not just in general populations, but specifically in older adult populations (Areán et al., 1993)

Stage 1: Problem Orientation

Problem Orientation is the first step in Social Problem Solving Therapy. The intentions of this stage are to make patients aware of their particular problems with daily living, to minimize the emotional content of the problems they face, and to increase their motivation in problem solving. The process of orientation consists of five distinct variables: problem perception, problem attribution, problem appraisal, personal control beliefs, and approach/avoidance style (Nezu, Nezu, Perri, 1989). Each of these variables must be addressed for each problem that the therapist and patient jointly tackle. In problem perception, the patient must identify a problem, and the context in which it is

faced. Though the problem might bring up emotions for the patient, it is essential that they try to put the emotional baggage aside so they can attend to the problem in a strategic, methodical fashion. With problem attribution, the patient, with the aid of the therapist, must try to achieve a realistic perspective of the cause of the problem. They might have an overly negativistic perspective and consequently attribute an unrealistic percentage of the blame on internal factors. Conversely, patients might have an attributional style that gives too much credence to external factors that might also be unrealistic. The patient must, then, attempt to find the realistic balance in order to disentangle the problem in a pragmatic fashion. In problem appraisal, the patient evaluates the problem in its significance and value to their personal well-being. The personal control variable is also important to address from the outset because patients must learn that they cannot change the behavior of others or many external circumstances. Instead, they have the opportunity to alter the way they react to the situations they cannot control, and to cope effectively with inevitable stressors. Additionally, the attitude with which the patient chooses to address the problem can make a difference. They must be proactive, rather than avoidant. They must not avoid issues that arise, but rather systematically address them. This issue might be particularly difficult for the patient with Executive Dysfunction to accomplish. The therapist must then make a concerted effort to encourage the patient to be motivated. Once these tasks have been accomplished, the patient and therapist will be ready to move on to Stage 2.

Stage 2: Definition

This stage is not only the most important, but it is also the most complex portion of therapy. The more well defined the problem is, the greater the likelihood of finding appropriate solutions that directly resolve the specified problem. In order to define the problem effectively, patient and therapist must gather all information about the problem. They must examine the context of the problem, the nature of the problem, and the perception of the problem by the patient. The patient must then, in clear and unequivocal words, make a statement of the problem. It is important for the patient to be specific and unambiguous so that once solutions are being generated, the solutions can be ones that address a particular problem, rather than a vague sentiment that cannot be solved. The therapist may need to give a lot more input with a patient with executive dysfunction. Though the patients should be learning the process for themselves, they might need extra coaching and participation from the therapist to accomplish this portion of SPST. This portion of SPST is further complicated because the patient must ask himself what the complications in resolving the problem are. They must address obstacles present impeding the path to resolution, as well as potential for loss of comforting factors, or increasing aversive stimuli, or increasing conflict as a result of resolving the current problem. The patient must acknowledge that the effects of solving one problem might affect another, especially if the problem is a complex one. Once again, in patients with executive dysfunction, the therapist might need to give substantial input. The therapist should permit the patient to try the step once the patient is comfortable enough to do so independently, but should be a supportive contributor until that point. Once the patient

has sufficiently defined the problem in clear terms, and extricated the problem they wish to work on from any complications that might be attached, they must proceed to setting a goal. Once again, the goal must be set in clear and unambiguous terms and the patient should be careful to be realistic in their expectations for resolution.

Stage 3: Generation of Solutions

In this step, patient and therapist brainstorm as many possible solutions to the defined problem as possible. Once again, this might be extremely difficult for a patient with executive dysfunction. The therapist needs to be patient, and encourage the patient by making suggestions of solutions and giving positive reinforcement when the patient makes any attempt at generating solutions. Once there is a selection of solutions, the patient and therapist will choose from among the many solutions the most effective solution with the highest likelihood of success. It is essential that both patient and therapist suspend judgment until all possible solutions have been written down. Precipitately making judgments on possible solutions impedes the brainstorming process and limits the scope of solutions. Many tactics can be offered by the therapist to aid the patient in a block. For instance, the therapist can ask the patient what he would recommend for a friend to do in a similar situation. Or the therapist can ask the patient what they have tried in the past and whether slight alterations might increase the possibility of success for a particular solution. It is important that the therapist continue to encourage the patient to generate solutions for the maximum possible amount of solutions to choose from. In the case of a patient with executive dysfunction, the therapist can suggest solutions for the patient until the patient can eventually come up

with his own. The more solutions that are available, the greater is the likelihood of choosing a successful solution in the following step.

Stage 4: Decision Making

In this stage, the patient must assess the likelihood that a solution will be successful. They should examine each solution in turn, and consider potential outcomes of each solution. The patient should look at both the expected costs of the solution and the expected benefits. It is important to note that at this stage, if the patient has the sense that the solutions generated are not addressing the problem selected, that the initial problem might have been misstated and that the process might need to be repeated with particular attention to specifying the correct problem. Again, therapists must take an active role with patients with executive dysfunction until the patient has grasped the concept and is able to perform the task independently.

Stage 5: Solution Implementation and Verification

Here, the resolution must be evaluated and its effectiveness verified. First, the performance on the solution implementation must be assessed. If problems prevented the successful execution, the patient should review the steps they took and specify where the problems occurred. The patient might also need to reformulate the initial problem and redo the entire process. Patients must evaluate not only their success on the particular goal at hand, but also the global effects of their success, should they have been successful. The rationale behind SPST dictates that effective coping with problems leads to an alleviation of depressive symptoms. When a patient has dealt successfully with a

problem, it is important for the patient and the therapist to explicitly tie the improvements in depressive symptoms to the effective resolution. Once the patient feels they can grasp the steps of SPST and is motivated to execute the process by virtue of improving their depressive symptoms, they are likely to integrate SPST in their daily functioning and prevent future episodes of depression.

CHAPTER 5: OVERVIEW FOR THE THERAPIST

Social Problem Solving Therapy for Depression with Executive Dysfunction (SPST-ED) is a modification of the Social Problem Solving Therapy for Older Adults (SPST-OA) manual developed by Patricia A. Areán, Rebecca Schein and Michael Perri. It is important for anyone using this manual to read and refer to two excellent books on Social Problem-Solving Therapy: Social Problem Solving Therapy: Theory, Research and Practice (Nezu, Nezu and Perri, 1989) and Problem-Solving Therapy: A social competence approach to clinical intervention (D'Zurilla & Nezu, 1999).

SPST-ED and SPST-OA are similar, with some crucial differences in the delivery of care. Although session number and length are the same (12 fifty minute visits), therapists must spend more time ensuring that the strategies taught are well understood and the assignments created in session are feasible and concretely detailed. The use of memory aides is crucial – early in treatment, patients may need telephone reminders from therapists to implement the assignment, or may need to make sure plans are displayed in the open in the patient's home. The involvement of family members in more extreme presentations of ED may also be necessary early in treatment. We have found, however

that once patients begin to respond to treatment, the therapist will need to use fewer memory aides.

In order for SPST-ED to be effective, one must make sure the patient (1) understands the rationale behind the model and (2) understands its application. Educating and socializing the patient to therapy is often important with older people. Some have never been in therapy before, and therefore an explanation of how the treatment will work, how often you will meet, the importance of homework and so forth will be very important to detail in the first session. A good geriatric therapist always asks patients what their expectations are of therapy, and tries to allay any concerns or misconceptions. Some older people have had psychotherapy in the past, but most likely will not have been exposed to a structured therapy like SPST-ED. It is important, in this case, that the patient understand the difference between SPST-ED and traditional psychotherapy. Telling the patient that they will be learning a new set of skills rather than relying exclusively on discussion of problems is a key difference between SPST-ED and traditional therapies.

There are some crucial components to the effective delivery of SPST-ED. It is important to use as many methods of delivery as possible. We call this procedure "Say it- Show-it, Do-it". When teaching an older person how to use this model, it is important to first explain clearly the rationale for the step, how the step is to be used, and when it is to be used. After explaining the problem-solving step to the patient, it is very important to ask the patient if they have questions. Next, demonstrate the step to the patient using an innocuous situation first, so that they understand how to apply the step. Then demonstrate the step using one of their own, less emotionally charged problems. After

you have demonstrated the step, ask the patient if they have any questions. Finally, have the patient use the step with you in the room. Help and guide them as much as possible, but do not do it for them.

With more impaired patients, it may be worthwhile to use the home environment and significant others to facilitate learning the SPST steps. If you are able to conduct home visits, placing cues around the patient's home to remind them to do homework may be helpful. Teaching patients to use a diary or calendar to specify when they will do the homework and setting up reminder calls early in treatment may also be of help. If all else fails, enlisting the help of a friend or family member to guide the patient through the homework may be necessary.

In the back of this manual is a week-by-week outline of what is to be covered in each session. This will help you plan the session with your patients. In the pages that follow this introduction will be the lectures and exercises for each session. These are details you can use to flesh out the sessions. It is not necessary to repeat the lessons verbatim – tailor the lesson for the patient. Just make sure the main points for the session are covered.

CHAPTER 6: SESSION GUIDE FOR THERAPISTS

SPST-ED Session Outline

Session 1: Introduction

- Set agenda for meeting

- Mini lecture:
  - Overview of Depression
  - Rationale for SPST
  - What to expect from treatment: organization of treatment

- Questions about mini lecture, expectations about treatment

- Review SPST stages
  - Introduce the forms
  - Run through a simple problem with the group
  - Discussion

- Problem List
  - Rationale

- Homework: Generate problem list and organize into a hierarchy

- Session review and last minute questions

Session 2: Problem Orientation

- Set Agenda

- Review Homework
  - Discuss problems and successes

- Mini lecture: Problem Orientation
  - Red Flags
  - Stop and Think
  - Problems as solvable
  - Devil's Advocate
  - Questions

- Demonstration of Problem Orientation worksheet

  - Questions

Homework: Problem Orientation worksheet when feeling depressed.

Session 3: Defining Problems

- Set Agenda

- Review Homework
  - Discuss problems and successes

- Mini lecture: Defining Problems
  - Big problems versus smaller problems
  - Breaking it down
  - Colombo technique
  - Facts versus assumption
  - Being clear
  - What is the goal and can you measure it?

- What is getting in the way?
- Questions

- Demonstration of Problem Definition worksheet

- Questions

Homework: Use Problem Orientation and Definition worksheets when feeling depressed.

Session 4: Brain storming

- Set Agenda

- Review Homework
  - Discuss problems and successes

- Mini lecture: Brain-storming
  - Quantity versus quality
  - Yes-But
  - Separate out brain-storming form evaluating
  - Questions

- Demonstration of Brian-Storming worksheet

- Questions

Homework: Use Problem Orientation, Definition and Brainstorming worksheets on at least one problem this week.

Session 5: Making a Choice and making a plan

- Set Agenda

- Review Homework
  - Discuss problems and successes

- Mini lecture 1: Making the best choice
  - Pros and Cons
  - Meeting short and long term goals
  - Impact on you and others
  - Feasibility
  - The final score
  - Questions

- Demonstration of Decision Making worksheet

  - Questions

- Mini lecture 2: Making the plan
  - Break it down into small steps
  - What do you need to implement the plan?
  - Scheduling it
  - Pick a reward now!
  - Questions

- Demonstration of Planning worksheet

  - Questions

Homework: Implement your chosen plan and use the five worksheets on at least one problem this week.

Session 6: Did it work?

- Set Agenda
- Review Homework
  - Discuss problems and successes
- Mini lecture: Evaluating the plan
  - If it worked, think why
  - If it didn't, think why and redefine your problem
  - Questions
- Demonstration of evaluation worksheet
  - Questions
- Demonstration of SPST stages for another problem

Homework: Use SPST worksheets on at least one problem this week.

Sessions 7- 10: Using the SPST forms

- 1' Set agenda
- 1' Review homework
- 1' Review progress

Homework: Use SPST worksheets on at least one problem this week.

Sessions 11-12: Relapse Prevention

- 1' Set agenda
- 1' Review homework
- 1' Review progress
- 1' Problem Solving how to prevent recurrence of depression
- 1' Plan to solve other problems

CHAPTER 7: OVERVIEW FOR THE PATIENT

This program is meant to help you cope with the problems that may be influencing your mood and your quality of life. We believe that by teaching you a way to objectively solve your problems that you will experience less stress, depression and worry.

What is depression? Depression is a condition that is created by a combination of life stress and chemical imbalance in the brain. Symptoms of depression include: feeling sad, blue, down or depressed nearly every day for at least two weeks; loss of appetite (sometimes an increase in appetite); poor sleep; feeling tired or restless; feelings of guilt or worthlessness; thinking you would be better off dead, or actually thinking of suicide. These symptoms, while troubling, are treatable.

How is it treated? People with depression have several options available to them to treat their symptoms, including medication, insight oriented therapy, structured therapy, and the therapy described here, called Social Problem Solving Treatment. All of the treatments listed here have been found to be very effective in treating depression symptoms in people your age.

What causes depression? Researchers are not 100% certain, but they believe that people are born with a tendency to react to stress by becoming depressed. Not everyone with this tendency becomes depressed, though. Whether or not you experience the symptoms related to depression depends on two key factors: the amount of stress you are under and your ability to handle this stress. If you experience a major life change that you do not know how to handle or solve, you may begin to feel helpless. If your repeated attempts to work through the problem do not work, you will start to feel hopeless. These feelings can trigger the chemical reaction in your brain that cause all the other symptoms of depression. Because symptoms like fatigue, lack of energy, lack of interest in things and so forth also sap your energy, you become less likely to try and solve your problem and therefore, feel even more helpless and hopeless. In other words, you fall into a vicious cycle that becomes very hard to break.

How does Social Problem Solving work? This therapy treats depression by giving you the skills to solve the problems that are making you feel depressed and to cope with those problems you cannot change. Over the next few weeks, you will learn a step-by-step process that will help you think about your problems and depression in a way that will make handling the problems easier.

The first step you will learn is called problem orientation. In this step, you will learn to use your feelings and symptoms of depression to help you identify when you are faced with a problem that contributes to your feelings of helplessness and hopelessness. You will then learn to check the way you see the problem: Are you thinking that the

problem is unsolvable, or are you thinking that there is no way to change this problematic situation, or are you thinking that the problem can be solved, you just need to sit down and think it through? How you look at the problem troubling you will determine whether or not you end up trying to handle it.

The second step is called problem definition. In this step, you will learn how to figure out what you would like to change, what is getting in the way of that change, and think about your problems in a concrete and objective way. The more concrete and objective you are about your problems, the easier it is to think of solutions. As you will see, a problem defined is a problem half solved.

In the third step, called brainstorming, you will learn how to come up with creative solutions to your problems, once you have defined them and set a goal. You will learn how prematurely discarding a solution before you have had a chance to evaluate it can defeat your attempts to solve your problems.

In the fourth step, called decision-making, you will learn how to apply a step of guidelines for determining whether or not a solution will work for you. You will learn how to evaluate the solution in terms of its impact on short term and long term goals, how it would affect other people, and whether or not it is a solution you can do.

The fifth step is called solution implementation. Once you have identified a good solution, you will then learn how to plan your strategy for using that solution, so that the chances of you actually using the chosen solution will be greater.

The last step is solution verification. This step is often taught along side the solution implementation step, as once you implement a solution, you will then need to

evaluate how effective it is, and whether or not you need to make any chances to it for the future.

We usually teach these steps to problem solving over a 5-week period. Each week you will learn a new step. Although this sounds slow, it is actually better that you learn each step well before you implement the whole model. In the grand scheme, five weeks is not that long, and you will eventually be able to solve your problems skillfully.

After you have mastered these steps, you will work with your therapists to make sure you can use the model. You will have an additional 6-7 weeks to work with your therapist to make sure that you can use the steps to solve your problems. You may or may not solve all your problems during this time. The most important thing is that you learn the problem-solving steps. Once you have done that, you can use this model on your own to solve any remaining problems you have.

How will I learn the steps? Each week, we will set an agenda for the meeting. We will first review your homework form the previous week to see how you did. Then, your therapist will show you how to use the next step in the process, and how to combine the new step with the steps you have learned already. You will practice the step a couple of times and decide on a problem you would like to practice with over the week. In the time remaining, you will have a chance to talk about any other issues you feel are important to raise with your therapist.

Homework is the most important part of the treatment. If you only use the steps when talking with your therapist, you will not likely learn how to use them. Like anything new you have to learn, you must practice it. That is all homework is initially - practice. Once you have learned the 5 steps of problem solving, you will be actively working on the problems that trouble you the most.

CHAPTER 8: SESSION EDUCATION MATERIALS FOR PATIENTS

PROBLEM ORIENTATION:

Nothing is either good or bad, but thinking makes it so.

-Hamlet

Have you heard this story? A man is driving along the countryside, when his car overheats. He looks under the hood, and finds he needs water for his radiator. He looks around and sees a farm in the distance, and thinks to himself, "Perhaps someone is at home and will lend me some water for my car." The man starts off for the farm, and along the way he thinks, "You know, I don't have a watering can. I'll need to borrow that, too. I hope it isn't too much to ask." He continues his walk, and thinks some more, "What if it is too much to ask? What if the people at home are put out by my request? What if they don't lend me the can or water?" Then he thinks, "What if they insist I pay them for the water and can? The nerve! I've heard of this before, people taking advantage of others in distress. I don't know what I'll do if that happens." He walks closer the farm, and sees the front door. As he approaches he thinks, "Yeah. I'll bet they try to soak me for all I'm worth. Just for a can of water! That just steams me up!" He gets to the door, very angry, and knocks loudly, all the while thinking these thoughts. Just as the door opens, and a farmer begins to speak, the man yells, "You can keep your stupid water!" and walks away.

What did you learn from this story? *(therapists here should have patients discuss how expectations can influence behavior. If you think that you won't get help, chances are you won't)*

- How thoughts affect behavior.

The most important thing to remember is that all problems have a solution. It may not be the one you want, and it may not solve your problem overnight, but there is always a way to handle a troubling situation.

The problem with depression is you no longer feel that is the case. People who are depressed very commonly have what is called "negative thinking". It's a little like seeing a glass of water as half empty, rather than half full, expecting the worst of things, feeling that you are incapable of doing anything "right". When you are feeling

depressed, this is a very easy trap to fall into, particularly if you have tried everything you can think of to solve the problem and have not been able to. Unfortunately, like the man in the story above, if you think you won't solve your problem, chances are you won't.

A number of years ago, the New York Times described a study in which some scientists said that people who were depressed saw the world more realistically than those who were not depressed. The truth is, people who are depressed may be more apt to notice the problems that are around them, but they are also less like to see the good around them, too. It is important to have balanced thinking, be aware of both the good and the bad equally.

- Red Flags

How do you know you are thinking negatively? You will know because you will feel:

- depressed
- angry
- anxious
- blue
- helpless
- hopeless

You may not feel all these things at once, but any of these feelings are a sign that you are not thinking about your problems in a way that will allow you to solve them. Emotion is like any other physical sensation in your body - it serves a purpose, a warning that you need to do something to fix a situation. When you break your leg, you feel pain when you stand on it - this pain tells you not to stand on the leg and to do something about the break. When you get into an argument with your children, you may begin to feel sad - that feeling is there to tell you something is not right between you and your child and that problem needs to be fixed.

Whenever you feel a strong reaction or feeling, this is a red flag to you that you have a problem that needs to be solved, and it's time to look at how you are thinking about the problem.

What are your red flags? *(Therapists here should have members talk about and list the typical feelings they have when a problem arises.)*

Negative Thinking and the Devil's Advocate

How do you stop from feeling depressed and hopeless? The first step is to make your thinking more balanced.

1 

When you start to sense a red flag, STOP AND THINK. Write down your thoughts. What do you say to yourself? What is going through your head? Are you trying to solve a problem, or are you just thinking about it and how had you feel?

2. Look at the thoughts and see if you can play the Devil's Advocate. Make an argument against the thoughts. Pretend you are an attorney trying to find holes in a witness's statement. What proof do you have that the thoughts you are having are correct?

The Problem Orientation Worksheet. Using the worksheet, try and change your most common negative thought into a thought that will allow you to try solving a problem.

Next Time: Defining the Problem

DEFINING THE PROBLEM

A problem defined is a problem half solved.

Once you are able to look at your problems and think about them in a more hopeful way, you are ready to try and define the problem. This is not as easy as it looks. You will need to ask yourself these questions when defining your problem:

- ***WHO*** is involved?
- ***WHERE*** does it happen?
- ***WHEN*** is this a problem?
- ***WHAT*** makes it a problem?
- ***HOW*** does the problem unfold?
- What is your ***GOAL***?
- What is getting in the way of your goal (***OBSTACLE***)?

This is called the COLOMBO technique.

You must make sure of one very important thing: Your problems should be defined in detail and concretely! Your goals must be measurable! *DON'T BE VAGUE*!!

If you are vague, you will have a very hard time coming up with solutions. Here is an example of why:

Vague problem: I procrastinate.

Vague goal: To get things done.

Vague obstacle: I don't know where to start.

Why is this vague? Procrastination means different things to different people. What does it mean to this person to procrastinate? Does she get some things done and not others? Does she put off everything? What does she want to get done? Housework, yard work, talking to her doctor, exercise? As you can see, this tells us very little about her goals and the problem.

Concrete problem: I have not moved my husband's things (clothes, medical equipment, medications) from our bedroom since he died. I need to return the equipment and all, but I can't do it myself (**WHAT**). This always bothers me at night, when I go in the bedroom, and when I think about getting rid of everything. I end up feeling overwhelmed and crying. Then I just go sleep on the couch**. (WHEN, WHERE, HOW**).

Concrete goal: To return the medical equipment by the end of the month, pack his clothes away, and throw away his pills.

Concrete obstacle: Not enough time, I start to get sad and lonely, it's too much for me to do alone.

Notice the difference here? This is ***the same*** person as in the first example, but after thinking about the details of the problem she is now in a better position to think up ways to solve the problem and it is less overwhelming to her.

You will also need to know:

- What is a fact and what is just your intuition
- What would you like to see happen? What is your long and short-term goal?
- Is this one simple problem, or a complex one that needs to be broken down further?

Separating fact from intuition. Your intuition may be good in general, but when you become depressed, it is often off course. In defining a problem, you have to be sure that the information you have is correct and that it is a fact – that you have proof of that information. One way to be sure is to pretend you are an investigative reporter. You cannot tell a story based on what you THINK happened, you have to tell it in terms of what you KNOW happened.

Think about this situation. You ask your doctor about your last blood test. He says he'll get to it, and then doesn't mention it again. Which of these is probably true:

- It's bad news and he is afraid to say something.

- He didn't hear you.
- He forgot.
- He doesn't care enough about you to answer your questions.
- He is an idiot.
- He is preoccupied.
- He is getting divorced and can't concentrate.

The answer is...NONE ARE TRUE. Unless you ask the doctor why he forgot to answer your question, you will never know why he did.

D<u>Another word about goals.</u> *Don't let what you cannot do interfere with what you can do (John Wooden).*

Not only do goals need to be concrete, they need to be reachable. Sometimes we get discouraged about our problems because we are trying for a goal that is not likely to happen. For instance, if you have a chronic illness, like diabetes, the goal of no longer having diabetes is not reachable, because there is no cure. However, if your goal is to overcome the problems that diabetes causes – like feeling tired and having high blood sugars, then your goal is reachable because there are things that you can do to control your fatigue and blood sugars. Think about the problems you are having and the goals you have – are they reachable?

(Therapists: Here, make sure that the patient goes through the problem list and has realistic goals).

Big versus small problems.

Sometimes we have a hard time solving a problem because it feels so overwhelming. This feeling usually means that you are not thinking about one simple problem, but a complex one that is actually made up of several smaller problems. When you are feeling overwhelmed (some people start to feel anxious), stop a moment and think about all the things running through your mind. Start to write it all down and then look at what you have written. Is this really and truly one big problem, or is it several problems that are all linked together? With these big problems, it is important to try and break them into smaller steps.

Take for example the problem of having too many medical bills and not enough money to pay them and your other expenses. If you try and tackle all of those bills at once, you will start to feel confused and overwhelmed. However, if you work on the problem of making sure you have a way to get your medication - and only work on that problem for the moment, then the problem is much easier to solve.

T Exercise: Take one of your own big problems and try and break it down into smaller pieces here.

Overall problem:

Problem 1:____

Problem 2:____

Problem 3:____

Problem 4:

Problem Definition Work Sheet:

Talking all that we have discussed above, let's now move to the problem definition work sheet. Using this worksheet, let's first try and define the problem:

"I need to improve my health"

Therapists: Once the patient has defined this problem, have them pick an easy problem form their problem list.

Next time: Brainstorming

Brainstorming

Don't put all your eggs into one basket.

-anon.

Now that your problem is defined, you have a goal and you have thought through all the obstacles, you are ready to think about ways you can reach your goal. Some people have a pretty easy time with this – once they realize what is specifically wrong and what is getting in the way of achieving the goal, they see what needs to be done. Most people, particularly those who feel depressed, still have a hard time thinking of ways to solve their problems. Why is that?

Scientists who have studied how people make decisions and solve problems have found that when people have to think of solutions for a problem, they usually can come up with an average of 10 solutions per problem. BUT, people who are depressed can only come up with 1 or 2 solutions that tend to be vague. The reason is this. People who are not depressed are able to *brainstorm* ideas and can think about the effectiveness of the solution objectively – that is they don't throw out solutions because they aren't perfect. People who are depressed, though, tend to evaluate solutions very negatively, and throw out solutions before really thinking about how effective it is. When this happens, it is difficult to brainstorm and come up with a list effective solutions to a problem. This makes you feel hopeless, helpless and sad.

There is no one, perfect solution that will solve your problem. There are probably several ways to solve your problem each with their own pros and cons.

How to brainstorm. The easiest way to brainstorm is to write down ALL the ideas in your head without thinking about how useful it is. That is, WITHHOLD YOUR JUDGEMENT.

?You may wonder what is the point of writing down ideas if they aren't going to be useful? It's simple – sometimes a bad idea can be a very useful one, as long as you tweak it and change it to fit the problem. Let's try it with a simple situation:

T List all the uses there are for a brick, no matter how silly they are (come up with at least 10):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Once while doing this exercise, a person said a good use for a brick was to break windows. Even though this sounds like a silly and pointless use for a brick, we began to think about when is breaking in windows with a brick a GOOD solution? The group came up with these examples:

1. You see a friend passed out in her house and you have no other way in to help her.
2. There is a fire in your house and you need to get out.
3. Your keys are stuck in your car and you are in a remote place with no cell phone.

Can you think of other times when this would be a good solution?

* Let's try to brainstorm with a real problem. Take a problem from your list, and first use the problem definition sheet to define it, then using the brain storming sheet, come up with at least ten solutions for the problem.

Homework: Use the brainstorming work sheet on another problem this week

(Therapists: If this exercise took little time, then go on to the next section - decision making without the planning.)

Making a Choice and Making a Plan.

It's not hard to make decisions when you know what your values are.

-Roy Disney

Don't judge those who try and fail, just those who fail to try.

-anon.

Now that you have a list of solutions in front of you, the next step is to choose the best solution and then make a plan to use it. It is not easy to make a decision as to which solution will be the best one for you and the problem you have. However, there are some questions you can ask yourself as you evaluate each solution. The answers to these questions will help you decide which solution you should choose.

The questions are:

- Does this solution meet my immediate goal?
- Does this solution help me meet my long-term goal (if any)?
- Does this solution create other problems for me?
- Does this solution create a problem for other people?
- Is this solution feasible (can I do it)?

Using these questions as a guide will help you decide what the pros and cons are for each solution.

T Using the Decision Making work sheet, think about each question for each solution and in the grid, mark a (+) if the solution has a positive impact in that are and a (-) if it has a negative, or bad impact in that area. Count up all the + and -. That will help you order which solution will be the best of the lot to try.

Making your plan. Choosing a solution is only part of solving it – now you need to make a plan of action. The key steps are to think about what you need to do before you use the solution. Do you need to call someone, is there equipment you need, is there a certain time of day when you can do it? The best thing to do is picture yourself using the solution. What do you need and when will it happen?

E It is also important to pick a reward for yourself. Even if the solution didn't work, you need to pat yourself on the back for making the effort.

T Using the planning sheet, write out the steps to your solution. Don't forget to pick out a reward for yourself!

Next week: Did it work?

Did it work?

Success seems to be largely a matter of hanging on when others let go.

-William Feather

Failure is success if we learn from it.

-Malcolm S. Forbes

If you were able to implement your solution and it worked – CONGRATULATIONS! Now it's time to think about how it worked, what you liked about the solution, and if you would do anything differently. Remember not to attribute your success to some fluke – you worked hard on this problem and your hard work paid off!

If you didn't do it or the solution didn't work, that's good, too. You now have some more information about the problem you didn't have before. It is important to evaluate and think about the solution, why it didn't work and if any of that information is helpful in either redefining the problem or in modifying the solution.

T Using the evaluation work sheet, let's take your solution for last week and evaluate it. If you need to, use other worksheets to modify the definition of your problem, pick another solution or evaluate new solutions.

Putting it all together. We have now learned all the steps to Problem-Solving. It is time to put all the sheets together and start solving more problems. Looking at our list of problems, pick the next problem you would like to solve and use the sheets.

(Therapists: Be available to patient for feedback while solving the new problem).

Next week: The next few weeks will be focused on using the problem solving sheets to work on other problems.

Relapse Prevention

Even if you're on the right track, you'll get run over if you just sit there.

-Will Rogers

Never, never, never, never give up.

-Winston Churchill.

Now you know how to solve problems and are on your way to a happy, healthier life. However, it is important to remember that life is not problem-free and we have to be on our toes to solve problems as they arise, or get help when we can't do it ourselves.

- Scientists specializing in depression now know that depression is a chronic recurrent illness, much like diabetes. However, unlike diabetes, you don't have to be on medication the rest of your life and you aren't always sick. Like diabetes, you can prevent serious episodes of depression if you make some changes to your lifestyle and you have a plan for life to help you during those times when you are at the greatest risk of suffering another depression episode.

T Using the problem-solving sheets, let's solve the problem of "Preventing a Relapse"

Therapists: Make sure that the plan incorporates relapse prevention strategies like maintaining social contact, using daily activities, and a plan in case they can not prevent a relapse (who to call, what symptoms are most likely related to a relapse).

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